South Carolina Department of Labor, Licensing and Regulation

# South Carolina Board of Medical Examiners

P.O. Box 11289 • Columbia, SC 29211
Phone: 803-896-4500 • Fax: 803-896-4515 • www.llronline.com/POL/Medical

Complete all sections of this application by providing all of the requested information. You must notify the Board, in writing, of any address changes after you file this application in order to receive any further information. The application form itself is a public document obtainable under the Freedom of Information Act.

**Applying for:** ☐ **Licensed Acupuncturist** ☐ **Auricular Therapist** ☐ **Auricular Detoxification Therapist**

## PART I: Applicant Identifying Information

| 1. **Last Name** | 2. **First Name** | 3. **Middle Name** | 4. **Suffix (Jr., III)** |
|---|---|---|---|
| | | | |

| 5.**Title** ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr. | 6. **Maiden Name** |
|---|---|
| | |

| 7. **Mailing Address** (Street or PO Box, City, State, Zip) |
|---|
| |

| 8. **Home Address** (Street, City, State, Zip) | 8a.**County (SC Only)** |
|---|---|
| | |

| 8b. **Home Phone** | 8c.**Home Fax** | 8d. **Home Email** |
|---|---|---|
| | | |

| 9. **Business Name** | 9a. **Business Address** (Street address, not PO Box, City, State, Zip) |
|---|---|
| | |

| 9b. **Business Phone** | 9c. **Business Fax** | 9d. **Business Email** |
|---|---|---|
| | | |

| 10. **Place of Birth** (List City & State or Country) | 11. **Date of Birth MM/DD/YYYY** | 12. **Gender** ☐ Male ☐ Female | 13. **Race (For Statistical Purposes Only)** ☐ African American/Black ☐ American Indian ☐ Asian/Oriental ☐ Hispanic/Spanish Origin ☐ Caucasian/White ☐ Other |
|---|---|---|---|
| | | | |

## PART II: Education Information

| SCHOOL NAME | LOCATION (City and State or Country) | DATES OF ATTENDANCE | | GRADUATED Yes/No | HIGHEST GRADE COMPLETED OR DEGREE EARNED |
|---|---|---|---|---|---|
| | | FROM (Month/Year) | TO (Month/Year) | | |
| | | | | | |
| | | | | | |
| | | | | | |
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**Are you a graduate from a program outside the United States?** **YES ☐ NO ☐**

### Professional Education

List in chronological order from date of graduation to the present all professional education not including continuing education coursework (i.e., apprenticeship, intern, residency, vocational training practical or clinical training,).

| INSTITUTION NAME | LOCATION (City and State or Country) | DATES OF ATTENDANCE | | DID YOU COMPLETE PROGRAM |
|---|---|---|---|---|
| | | FROM (Month/Year) | TO (Month/Year) | |
| | | | | **YES ☐ NO ☐** |
| | | | | **YES ☐ NO ☐** |
| | | | | **YES ☐ NO ☐** |
| | | | | **YES ☐ NO ☐** |

*The Social Security Number (SSN) is not subject to disclosure as public information. The disclosure of the SSN for identification purposes is authorized and mandated by federal statutes requiring state boards to report to the Healthcare Integrity and Protection Data Bank (HIPDB) and the National Practitioner Data Bank (NPDB), among other things. (Revised 7/10/12)

## PART III: Record of Licensure Examination

Complete the requested information below to include examinations taken in this state or any other state. Use additional paper if necessary. Failure to disclose an examination attempt may result in the denial of your application or other appropriate action.

| Name of Examination | State or Country | Date of Examination | Number of Attempts | Passed/Failed/Score (If score, enter score) |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
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## PART IV: Record of Licensure Information

Complete the requested information below if you have ever been licensed, certified or registered to practice in any profession or occupation. You must identify the method by which you obtained your license(s). You must include jurisdiction both within and outside the United States. Failure to disclose all licenses held may result in denial of your application or other appropriate action. (Attach additional sheets if necessary.)

| Jurisdiction | Credential Type | License Number/Name on License | How License Obtained (Type of Exam or Endorsement) | Date of Initial Issuance |
|---|---|---|---|---|
| **State or Country of Original (Initial) Licensure:** | | | | |
| **State or Country of Current licensure where you most recently practiced:** | | | | |
| **List Other Jurisdictions of Licensure:** | | | | |
| | | | | |
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## PART V: Employment History

List all related employment chronologically for the past five (5) years. If you have never been employed in the profession you are applying for, insert "N/A" for Not Applicable in Box 1. You are authorized to photocopy this form if additional space is required.

| | | |
|---|---|---|
| **1. Company Name** | **Company Address (Street, City, State, Zip)** | |
| **Job Title** | **Type of Employment** ☐ Full-time ☐ Part-time | **Date of Employment** **From: _____ To: _____** |
| **Abbreviated Description of Duties Performed** | **Hours Worked per Week** | **Reason for leaving** |
| | | |
| **2. Company Name** | **Company Address (Street, City, State, Zip)** | |
| **Job Title** | **Type of Employment** ☐ Full-time ☐ Part-time | **Date of Employment** **From: _____ To: _____** |
| **Abbreviated Description of Duties Performed** | **Hours Worked per Week** | **Reason for leaving** |
| | | |
| **3. Company Name** | **Company Address (Street, City, State, Zip)** | |
| **Job Title** | **Type of Employment** ☐ Full-time ☐ Part-time | **Date of Employment** **From: _____ To: _____** |
| **Abbreviated Description of Duties Performed** | **Hours Worked per Week** | **Reason for leaving** |
| | | |
| **4. Company Name** | **Company Address (Street, City, State, Zip)** | |
| **Job Title** | **Type of Employment** ☐ Full-time ☐ Part-time | **Date of Employment** **From: _____ To: _____** |
| **Abbreviated Description of Duties Performed** | **Hours Worked per Week** | **Reason for leaving** |
| | | |
| **5. Company Name** | **Company Address (Street, City, State, Zip)** | |
| **Job Title** | **Type of Employment** ☐ Full-time ☐ Part-time | **Date of Employment** **From: _____ To: _____** |
| **Abbreviated Description of Duties Performed** | **Hours Worked per Week** | **Reason for leaving** |

## Part VI: Personal History Information

If you answer "**yes**" to any of the questions below (1-11), you must attach a full written explanation pertaining to that particular question.

1. Have you ever had any application for any professional license, certification, or registration refused or denied by any licensing authority? **YES ☐ NO ☐**

2. Have you ever been refused or denied the privilege of taking an examination required for any professional licensure? **YES ☐ NO ☐**

3. Have you ever been the subject of disciplinary action with regard to a license, been revoked or sanctioned by any licensing authority, association, licensed facility, or staff of such facility? **YES ☐ NO ☐**

4. Have your privileges ever been restricted or terminated by any association, licensed facility, or staff of such facility; or have you ever voluntarily or involuntarily resigned or withdrawn from such association or facility to avoid imposition of such measures? **YES ☐ NO ☐**

5. To your knowledge have any unresolved or pending complaints ever been filed against you with any federal or state agency, professional association, licensed hospital/clinic, or staff of such hospital or clinic? **YES ☐ NO ☐**

6. Have you ever been arrested, indicted or convicted (including a nolo contendere plea or guilty plea) for violation of any federal, state or local law (other than minor traffic violations)?
   **If yes, have a certified copy of the court records regarding your conviction, the nature of the offense date of discharge, if applicable, as well as a statement from the probation or parole officer sent directly to the Board from the above mentioned authorities.** **YES ☐ NO ☐**

7. Currently or within the last five years, have you been treated for drug or alcohol addiction that might interfere with your ability to competently and safely perform the essential functions of practice? **YES ☐ NO ☐**

8. Have you ever been court martialed or discharged other than honorably from the armed service? **YES ☐ NO ☐**

9. Currently or within the last five years, have you been treated for any physical, mental, or emotional condition that might interfere with your ability to competently and safely perform the essential functions of practice? **YES ☐ NO ☐**

10. Currently or within the last five years have you developed any disease or conditions, physical, mental or emotional that might interfere with your ability to competently and safely perform the essential functions of practice? **YES ☐ NO ☐**

11. Have you been known by any other name or surname? **YES ☐ NO ☐**

## PART VII: AFFIDAVIT

I, _____ (**print name**), am the person described and identified, of good moral character, and the person named in all documents presented in support of this application. I have carefully read the questions in the foregoing application and have answered them completely, without reservations of any kind, and I declare that all statements made by me herein are true and correct. Should I furnish any false or incomplete information in this application, I hereby agree that such act shall constitute the cause for denial or revocation of my license to practice as an Acupuncturist in South Carolina.

I hereby authorize all hospitals, medical institutions or organizations, my references, personal physicians, employers (past and present), business and professional associates (past and present) and all governmental agencies and instrumentalities (local, state and federal) to release to this licensing Board any information, files, or records requested by the Board for its evaluation of my qualifications for acupuncture practice in South Carolina. I hereby release, discharge and exonerate the State Board of Medical Examiners of South Carolina, its agent or representative and any person or organization furnishing information from any and all liability of every nature and kind arising out of the furnishing of documents, records or other information, or arising from the investigation made by the State Board of Medical Examiners of South Carolina.

I have carefully read the questions in the foregoing application and have answered them completely, and I declare that all statements made by me herein are true and correct. Should I furnish any false or incorrect information in this application, I hereby agree that such act may constitute cause for denial or revocation of my license to practice in South Carolina.

I hereby authorize the South Carolina Board of Medical Examiners to utilize my Social Security Number (SSN) in making necessary reports to the Federation of State Medical Boards' Physicians Data Center for compilation of information about applicants and licenses in order to coordinate licensure and disciplinary activities between the individual states' licensing boards, and to federal and state entities, as required by law.

_____
Signature of Applicant (Do not print)

_____
Printed Name of Applicant

Subscribed and sworn before me this _____ day of

_____, 20_____.

_____
Notary Public

My Commission Expires: _____

Attach Photo Here

(2x2)

No copies

Do Not Staple

### INTERVIEW AND APPROVAL

Committee/
Board Member_____

Date approved_____

**For Office Use Only**

Date Received: _____

Paid by: ☐Check ☐Money Order ☐ Cash

Check/Money Order No: _____ Amount: _____

Control No. _____ Deposit No. _____

# AFFIDAVIT OF ELIGIBILITY

Pursuant to section 8-29-10 of the South Carolina Code of Laws (1976 as amended), the Department of Labor, Licensing and Regulation must verify the lawful U.S. presence of any person who applies for a South Carolina license. Please complete and sign this Affidavit of Eligibility. The information provided is subject to verification.

**Section A: LAWFUL PRESENCE in the United States.**

I, (please print your full name) _____, swear or affirm under penalty of perjury under the laws of the State of South Carolina that (check 1, 2 or 3 below):

1. ___ I am a United States citizen or legal permanent resident eighteen years of age or older; or

2. ___ I am not a US citizen but am lawfully present in the US as evidenced by one of the following
   a. ___ I am a qualified alien as defined in 8 U.S.C. sec 1641, eighteen years of age or older.
   b. ___ I am a nonimmigrant under the "Immigration and Nationality Act," Federal Public Law 82-414 as amended, eighteen years of age or older.

3. ___ I am not physically present in the US under 8 U.S.C. sec 1621 (c) (2) (c) or employed in the US pursuant to 8 U.S.C. 1621 (c) (2) (a) (check either a or b below):
   a. ___ I am a US citizen, not physically present or employed in the United States.
   b. ___ I am a Foreign National, not physically present or employed in the United States.

***If you selected either 3.a. or 3.b., you do not need to complete Section B. Skip to Section C.***

**Section B: Secure and Verifiable Document.** This section must be completed if you checked number 1 or 2 in Section A.

1. Please check the acceptable secure and verifiable document(s) you hold. A copy of the verifiable document(s) must be attached to the Affidavit of Eligibility.

☐ A valid South Carolina Driver's License, South Carolina Driver's Permit or South Carolina Identification Card. Number _____; Date of Expiration: _____

☐ A valid out-of-state issued photo Driver's License or photo identification card, photo driver's permit. State: _____; Number_____; Date of Expiration: _____.

☐ Permanent Resident Card; Alien Number _____; Card Number _____; Date of Expiration: _____.

☐ Employment Authorization Card; Alien Number _____; Card Number _____; Date of Expiration: _____

☐ Certificate of Naturalization with intact photo.

☐ Certificate of (US) Citizenship with intact photo.

☐ Other: (Name of verifiable document) _____

2. Enter the state or the federal agency name where the secure and verifiable document(s) was issued.

_____
(If issued by a state agency, include both the state and agency name.)

3. Please provide your social security number: _____/_____/_____
(Include a copy of the card with the Affidavit)

**Section C: Attestation.**

- I understand that this sworn statement is required by law because I have applied for or seek reinstatement of a professional or commercial license as provided for in 8 U.S.C. §1621. I understand that state law requires me to provide proof that I am lawfully present in the United States.
- I understand that in accordance with section 8-29-10 of the South Code, a person who knowingly and willfully makes a false, fictitious, or fraudulent statement or representation in an affidavit shall be guilty of a felony.
- I am the person identified above, and the information contained herein is true and correct to the best of my knowledge. I understand that under South Carolina law, providing false information is grounds for denial, suspension or revocation of a license, certificate, registration or permit.

_____ _____
Signature Date

_____
Please print your name as shown on your secure and verifiable document.

Professional License Type: _____

License Number (if already licensed): _____

*The South Carolina Law requires that every individual who applies for an occupational or professional license provide a social security number for use in the establishment, enforcement and collection of child support obligations and for reporting to certain databanks established by law. Failure to provide your social security number for these mandatory purposes will result in the denial of your licensure application. Social security numbers may also be disclosed to other governmental regulatory agencies and for identification purposes to testing providers and organizations involved in professional regulation. Your social security number will not be released for any other purpose not provided for by law.*

06/28/12 Affidavit of Eligibility
10/05/12 Revised

# Summary of Requirements for Acupuncture Practice

Applicants applying for a license to practice acupuncture must submit the following documentation:

1. Completed original application. (Copies not accepted). This includes the Affidavit of Eligibility.
2. Fee - Non-refundable application fee of $111.00 is required with your application. Your application will not be processed until the $111.00 application fee has been received. Make check payable to **LLR-Board of Medical Examiners.**
3. Submit a copy of your acupuncture diploma.
4. Submit a copy of your active certification in acupuncture by the National Commission for the Certification of Acupuncturists and Oriental Medicine (NCCAOM).
5. Verification of licensure – A verification form is enclosed and may be duplicated as needed. This Board must receive verification of licensure directly from the state board of each state in which you are *now or have ever been licensed* to practice acupuncture.
6. Interview and temporary license - When your application is complete, an interview is required with a member of the committee or a designated board member before a temporary license may be issued. At the next committee meeting the entire application will be considered, and if qualified, the committee may recommend to the board that a permanent license be issued. If the committee declines to recommend issuance of a permanent license, the committee may extend or withdraw the temporary license. During this interview you must present your original diplomas and training certificate, if applicable.

Please note:

1. Application and fee will be kept on file for twelve (12) months; thereafter, a new application and fee are required. Applications will be processed within three weeks of received date.
2. Please mail, fax or email your address changes in writing immediately to the Board.
3. It is a violation of state law if an acupuncturist practices before being issued a license. Violators are subject to fines and possible criminal prosecution.

# Summary of Requirements to Perform Auricular Therapy

Applicants applying for a license to perform Auricular Therapy must submit the following documentation:

(1) Completed original application. (Copies not accepted)

(2) Fee - Non-refundable application fee of $111.00 is required with your application. Your application will not be processed until this $111.00 application fee has been received. Make check payable to **LLR-Board of Medical Examiners**.

(3) Submit a copy of your certification as having been trained to utilize auricular points.

(4) Successful completion of a national certified program approved by the Acupuncture Advisory Committee and the State Board of Medical Examiners;

(5) Copy of your certificate documenting successful completion of a nationally recognized clean needle technique course.

(6) Verification of licensure – A verification form is enclosed and may be duplicated as needed. This Board must receive verification of licensure directly from the state board of each state in which you are *now or have ever been licensed* to practice auricular therapy.

(7) Supervisor form completed. Auricular therapy may take place under the supervision of a licensed acupuncturist or a person licensed to practice medicine.

(8) Interview and temporary license - When your application is complete, an interview is required with a member of the committee or a designated board member before a temporary license may be issued. At the next committee meeting the entire application will be considered, and if qualified, the committee may recommend to the board that a permanent license be issued. If the committee declines to recommend issuance of a permanent license, the committee may extend or withdraw the temporary license. During this interview you must present your original diplomas and training certificate, if applicable.

**Please note:**

1. Treatment by an auricular therapist is strictly limited to inserting needles into the ear. Inserting needles anywhere else on the body is considered practicing acupuncture without a license.

2. Application and fee will be kept on file for twelve (12) months; thereafter, a new application and fee are required. Applications will be processed within three weeks of received date.

3. Please mail, fax or email your address changes in writing immediately to the Board.

4. It is a violation of state law if an acupuncturist practices before being issued a license. Violators are subject to fines and possible criminal prosecution.

# Summary of Requirements to Perform Auricular Detoxification Therapy

Applicants applying for a license to perform Auricular Detoxification Therapy must submit the following documentation:

(1) Completed original application. (Copies not accepted)

(2) Fee - Non-refundable application fee of $111.00 is required with your application. Your application will not be processed until this $111.00 application fee has been received. Make check payable to **LLR-Board of Medical Examiners**.

(3) Copy of your certificate documenting that you have successfully completed a nationally recognized training program in auricular detoxification therapy for the treatment of chemical dependency detoxification and substance abuse.

(4) Copy of your certificate documenting successfully completion a nationally recognized clean needle technique course.

(5) Verification of licensure – A verification form is enclosed and may be duplicated as needed. This Board must receive verification of licensure directly from the state board of each state in which you are *now or have ever been licensed* to practice auricular Detoxification therapy.

(6) Supervisor form completed. Auricular detoxification therapy may take place under the direct supervision of a licensed acupuncturist or a person licensed to practice medicine.

(7) Interview and temporary license - When your application is complete, an interview is required with a member of the committee or a designated board member before a temporary license may be issued. At the next committee meeting the entire application will be considered, and if qualified, the committee may recommend to the board that a permanent license be issued. If the committee declines to recommend issuance of a permanent license, the committee may extend or withdraw the temporary license. During this interview you must present your original diplomas and training certificate, if applicable.

**Please note:**

1. Treatment by an auricular detoxification therapist is strictly limited to the five ear-point treatment protocol for detoxification, substance abuse, or chemical dependency as stipulated by the National Acupuncture Detoxification Association (NADA).

2. Application and fee will be kept on file for twelve (12) months; thereafter, a new application and fee are required. Applications will be processed within three weeks of received date.

3. Please mail, fax or email your address changes in writing immediately to the Board.

4. It is a violation of state law if an auricular detoxification therapist practices before being issued a license. Violators are subject to fines and possible criminal prosecution.

**Information below is to be completed by the**

# SUPERVISING PHYSICIAN OR ACUPUNCTURIST

**For an**

# Auricular Therapist or Auricular Detoxification Therapist

(Please type or print clearly) SC License Number:_____

Name:_____
First Middle Last name

Address:_____

City:_____ State:_____ Zip:_____

Home telephone: ( )_____ Office telephone: ( )_____

1. List and attach copies of all acupuncture training.

| School | Course | Date completed |
|---|---|---|
| | | |
| | | |

2. Describe below the nature of the working relationship for the auricular therapist or auricular detoxification therapist. (Attach additional pages if necessary)

3. Describe below the types of conditions for which acupuncture will take place. (Attach additional pages if necessary)

- I acknowledge and agree, if approved by the Board, that I shall be responsible for supervising the auricular therapist or directly supervising of the auricular detoxification therapist named in this application. I further acknowledge that as the supervising physician or acupuncturist, I will be available to attend to any unexpected, adverse effects.

- I agree that should I become aware of any unethical, unprofessional or illegal acts or omissions on the part of the auricular therapist or auricular detoxification therapist, I shall immediately report such conduct in writing to the State Board of Medical Examiners of South Carolina.

- I have carefully read the above questions and answered them completely and I declare that all statements made by me herein and materials supplied herewith are true and correct. Further, if approved as the supervising physician or acupuncturist of this auricular therapist or auricular detoxification therapist, **I agree to keep the Board informed of any future changes in my address or working relationship with this auricular therapist or auricular detoxification therapist**.

_____
Name of Auricular Therapist or Auricular Detoxification Therapist

_____ _____
(Date) (Supervising physician or acupuncturist signature)

## ACUPUNCTURE VERIFICATION OF LICENSURE

*Complete the top portion of this form and forward a copy to each state board by which you have now or have ever been licensed to practice acupuncture, auricular therapy or auricular detoxification therapy.*

In applying for a license to practice acupuncture in the State of South Carolina, the Board of Medical Examiners requires this form to be completed by each state wherein I hold or have ever held a certificate or license. My signature below is your authority to release any and all information in your file, favorable or otherwise, regarding myself, directly to:

**SC Dept. of Labor, Licensing and Regulation**
**Board of Medical Examiners**
110 Centerview Drive
P. O. Box 11289
Columbia, SC 29211
(803) 896-4500

Signature_____
Name_____
Address_____
_____
City State Zip

**DO NOT DETACH**

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***This section should be completed by an official of the state board and returned directly to the Board of Medical Examiners.***

This certifies that the records of the _____Board of Medical Examiners indicate that_____was issued license number_____certificate number_____on_____19____to practice acupuncture.

Certificate or license is current?_____If no, why not?_____

Has certificate or license been suspended, revoked, or restricted?_____ If yes, why?_____

Has applicant ever been requested to appear before your Board?_____If Yes, why?_____

_____

Derogatory information, if any_____

Comments, if any_____

_____

Signature:_____
Title:_____
BOARD SEAL Date:_____

PLEASE USE REVERSE SIDE FOR COMMENTS)